BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

RACHEL LOVAN, Claimant, vs. BROADLAWNS MEDICAL CENTER, Employer, and SAFETY NATIONAL CASUALTY CORPORATION, Insurance Carrier, Defendants.	FILED MAR 30 2018 WORKERS COMPENSATION	File No. 5058435 ARBITRATION DECISION Head Note Nos.: 1108.50, 1402.10, 1402.40, 1803, 2907

STATEMENT OF THE CASE

Rachel Lovan, claimant, filed a petition in arbitration seeking workers' compensation benefits from Broadlawns Medical Center, employer, and Safety National Casualty Corporation, insurance carrier, as defendants. Hearing was held on March 20, 2018 in Des Moines, Iowa.

Claimant, Rachel Lovan, and Jeffrey Johannes both testified live at trial. The evidentiary record also includes Joint Exhibits JE1-JE14, Claimant's Exhibits 1-5, Defendants' Exhibits A and E.

The parties filed a hearing report at the commencement of the arbitration hearing. On the hearing report, the parties entered into various stipulations. All of those stipulations were accepted and are hereby incorporated into this arbitration decision and no factual or legal issues relative to the parties' stipulations will be raised or discussed in this decision. The parties are now bound by their stipulations.

The parties opted not to submit any post-hearing briefs. The case was considered fully submitted at the close of the hearing on March 20, 2018.

ISSUES

The parties submitted the following issues for resolution:

1. The extent of permanent disability claimant sustained to her bilateral upper extremities as a result of the stipulated May 1, 2008 work injury.

2. Whether claimant is entitled to alternate medical care?

3. Assessment of costs.

FINDINGS OF FACT

The undersigned, having considered all of the evidence and testimony in the record, finds:

Claimant, Rachel Lovan, sustained a stipulated injury to her bilateral upper extremities while working for Broadlawns Medical Center (hereinafter "Broadlawns" or "defendant-employer"). The stipulated date of injury is May 1, 2008.

Ms. Lovan began working at Broadlawns on July 29, 2001. She was hired as a full-time file clerk. As a file clerk she was responsible for pulling and delivering charts or files around the hospital and clinic. The files varied in size, but some were larger than the size of a phone book. She would push a cart with the files. She was also responsible for filing the charts back on the shelves. She worked in this position for approximately one year. (Testimony)

She continued to work at Broadlawns, but transferred to the position of correspondence clerk. The correspondence clerk performs duties related to the release of medical information. In this position, her duties included helping patients at the window, sometimes completing handwritten forms for the patients, answering the phone, copying charts, and utilizing a typewriter and computer. (Testimony; Claimant's Exhibit 2, pages 3-5)

Around 2007 Ms. Lovan began to experience difficulties with her hands and arms. She had numbness and tingling in her fingertips and hands. She also had shooting pain in her arm, all the way up to her shoulder when she used her hands. She noticed that she used her hands a lot at work, especially when she was working with the charts. Ms. Lovan had problems with her hands at home and noticed that the symptoms in her hands and arms would keep her up at night. (Testimony)

Ms. Lovan went to see her primary care physician, William Maher, D.O. in 2007 or 2008. Ms. Lovan testified that Dr. Maher referred her to another doctor. (Testimony)

In 2008, Ms. Lovan reported her symptoms to the defendant-employer. Ms. Lovan was sent for an EMG in May of 2008. She had an abnormal electrodiagnostic study. There was a mild to moderate degree of bilateral median mononeuropathy consistent with carpal tunnel lesion, left greater than right. The studies showed no convincing electrophysiological evidence of brachial plexopathy, cervical radiculopathy, peripheral neuropathy, myopathic nor focal motor neuronopathic processes. (JE1)

Mark D. Fish, D.O., an orthopaedic surgeon at the Iowa Clinic, saw Ms. Lovan for bilateral wrist pain on August 5, 2008. He felt she had bilateral carpal tunnel. He gave her bilateral carpal tunnel injections. He also ordered another set of nerve tests. The second nerve tests were conducted by Todd C. Troll, M.D. on August 5, 2008. The findings were consistent with mild bilateral median neuropathy at the wrist. Ms. Lovan reported that the injections helped for approximately two weeks, but then the pain returned. Dr. Fish felt that because the injections did provide her with some relief, a carpal tunnel release might be beneficial for her. However, Ms. Lovan did not want surgery at that time. This was on September 2, 2008. (JE2)

On November 25, 2008, Ms. Lovan was sent to Delwin E. Quenzer, M.D. for a workers' compensation hand surgery initial consultation. Prior to the evaluation, Dr. Quenzer had reviewed Ms. Lovan's prior treatment and testing records. He noted that Ms. Lovan had a history of wrist pain that began several years ago and worsened in May of 2008. Ms. Lovan reported numbness in all digits bilaterally and said her hand felt heavy. Her symptoms were worse at night. She had already tried bilateral wrist splints. Dr. Quenzer noted that she had an administrative job at Broadlawns. It was his understanding that the job required occasional moderate lifting. She had to lift medical charts either individually or multiple files at a time. She also reported that she pulled charts. Ms. Lovan said there was repetitive grasping and pinching in her job along with repeated or sustained turning and twisting. Dr. Quenzer's impression was bilateral carpal tunnel syndrome. He felt she was a candidate for bilateral endoscopic carpal tunnel releases. Ms. Lovan wanted to proceed with the procedures. Dr. Quenzer's note indicates that his office would request authorization through workers' compensation. (JE3, pp. 1-4)

On December 22, 2008, Dr. Quenzer performed a left endoscopic carpal tunnel release. (JE4, p. 1) Ms. Lovan testified that she experienced approximately one month of relief following the surgery. Ms. Lovan returned to work on December 26, 2008. She believes she returned to work too quickly after the surgery. She returned to her full-time correspondence clerk position. By this time, Broadlawns had transitioned to electronic computer records, thus she no longer needed to make copies. She could generate copies by printing them from the computer. Ms. Lovan did have an increased amount of computer work. (Testimony)

Charles Denhart, M.D. conducted additional nerve testing on July 14, 2009. This was done at the request of Dr. Quenzer. The testing revealed residual left carpal tunnel syndrome. (JE5)

On August 10, 2009, Dr. Quenzer performed a right carpal tunnel release and right median neurolysis at the elbow. (JE4, p. 2) She was eventually released to return to work full duty. Again, Ms. Lovan only experienced approximately one month of relief. (Testimony)

On January 18, 2010, Dr. Quenzer issued his opinion with regard to permanent impairment sustained by Ms. Lovan. He noted that she underwent right carpal tunnel release and right median neurolysis on August 10, 2009 and left endoscopic carpal tunnel release on December 22, 2008. Dr. Quenzer opined that she did not have any ratable impairment of either upper extremity. (JE3, pp. 5-6)

On February 17, 2010, Ms. Lovan returned to see Dr. Quenzer. She continued to have pain and numbness in both her arms. The doctor's impression was postoperative state, both arms with residuals. He recommended repeat electrodiagnostic testing of both upper extremities. (JE3, p. 7)

Ms. Lovan saw Gregory J. Yanish, M.D. on March 5, 2010 for a second opinion regarding her bilateral carpal tunnel syndrome. Ms. Lovan reported that she did not have resolution of her carpal tunnel, her right wrist was especially uncomfortable. She feels that her symptoms have not improved at all. She had a significant amount of numbness and tingling that woke her at night and was very bad during her workday. She reported that her symptoms were much worse when she was sleeping, driving, or talking on the phone. Dr. Yanish's assessment was recurrent carpal tunnel syndrome, right greater than left. He sent her for additional nerve testing. The testing was performed on April 1, 2010. The impression from the testing was moderately severe right carpal tunnel syndrome (CTS), mild left CTS with sensory motor involvement and no evidence of ulnar nerve entrapment bilaterally. (JE6, pp. 1-24)

Dr. Yanish performed an open carpal tunnel release revision on her right wrist on June 8, 2010. (JE7) Ms. Lovan underwent some physical therapy to increase her right wrist motion during the summer of 2010. (JE8)

Dr. Yanish saw Ms. Lovan on July 7, 2010 for follow-up of her revision open carpal tunnel release on the right upper extremity. At that time, Ms. Lovan was ecstatic that her symptoms had dramatically improved. She reported that she felt the best she had in a long time. He returned her to work with restrictions. (JE6, pp. 5-6)

By July of 2010, Ms. Lovan reported that she was using her hand normally and was ready to return to work full-duty status. She was ready to consider revision treatment for her left side in a couple of months; first she wanted to get back to work to focus on her job for a while. (JE6, pp. 7-8)

Ms. Lovan returned to Dr. Yanish on November 12, 2010. She reported that her numbness and tingling in her right upper extremity had returned. She was miserable in both upper extremities. Dr. Yanish's assessment was paresthesias of bilateral upper extremities, carpal tunnel syndrome bilaterally and question of cubital tunnel syndrome on the right side. The doctor explained to Ms. Lovan that it was impossible for her to have all fingers numb at the same time. Dr. Yanish stated:

> There is no question in my mind that this patient's carpal tunnel is open. I triple confirmed this prior to closing the wound and her surgery given the fact that this was a revision surgery and this is also my usual protocol during surgery. There is no question in my mind that she does not have recurrent carpal tunnel on this after her second surgery.

(JE6, p. 9)

Ms. Lovan returned to Dr. Yanish on November 24, 2010. She reported that she had total weakness of her right upper extremity and pain radiating up into her upper arm. She returned with a short paragraph describing her symptoms, not a diary as the doctor had requested. She noted that when she used her computer mouse the tips of her thumb, pointer finger, and middle finger felt numb. The doctor noted she did not complain of any ulnar nerve symptomatology. Dr. Yanish felt strongly that she did not have a nerve compression issue in her upper extremity, but thought she might have something going on with her neck or even possible thoracic outlet syndrome. He recommended she see a specialist, such as Alan R. Koslow, M.D. of Heartland Vascular Medicine and Surgery. Dr. Yanish felt like he did not have any other treatment to offer her. He did not feel it would be worthwhile to revisit her left carpal tunnel. (JE6, pp. 11-12)

On May 4, 2011, Dr. Koslow sent a letter to Dr. Maher. He noted that he had seen Ms. Lovan and that she had a partial response to the CT-guided anterior scalene injection. She reported that her pain went from a 10 to a 5, but most of her residual pain appeared to be in her hand and forearm. Dr. Koslow felt this was likely the residual from her carpal tunnel and ulnar release surgeries. She was concerned about the scar from the potential surgery Dr. Koslow would perform and wanted to think about surgical treatment. Dr. Koslow recommended she return to Dr. Yanish. (JE9; Testimony)

On July 15, 2011, Ms. Lovan returned to see Dr. Yanish. She continued to report discomfort in her hands and was recently sent for a repeat EMG. Dr. Yanish stated:

> She is noted to have had worsening EMG on her right side, which in my entire career I have never seen. I have explained this to the patient today and spent a long time discussing this with her. After seeing the repeat EMG I am convinced that this patient does have something going on in her wrist, and there is a real reason for her continued symptoms. I have been straight forward [*sic*] with her today and told her that until I saw this

> EMG I was really quite skeptical. I do feel that there is an actual real issue going on causing continued median nerve compression, even though she has had two releases. I also feel that her second release which was performed by me was successful in that she did have a period of time where she had total resolution of her symptoms. This did come back slowly over time which I feel is caused from the transcarpal ligament regenerating and healing again.

(JE6, p. 13)

Dr. Yanish advised Ms. Lovan that she probably needed a repeat carpal tunnel release. He recommended a fat pad be placed between the edges of the transcarpal ligament to prevent regeneration. In the meantime, he gave her an injection into her right carpal tunnel. (JE6, pp. 13-14)

Donna J. Bahls, M.D. released Ms. Lovan to regular duty, no restrictions on March 29, 2012. (JE6, p. 15)

On April 16, 2012, Dr. Bahls assigned 5 percent upper extremity impairment for both arms due to residual carpal tunnel syndromes. Dr. Bahls noted that the symptoms affected her sleep and function at work and at home so she assigned another 3 percent whole person impairment for pain. The total impairment assigned by Dr. Bahls equated to a total of 9 percent whole person impairment. She also stated that Ms. Lovan required medication to help her deal with her bilateral upper extremity symptoms and would need monitoring every 6 to 12 months for the medication. (JE6, p. 16)

On January 20, 2014, Dr. Bahls conducted additional nerve testing. The impression from the testing was bilateral CTS, slightly improved since the July 5, 2011 study. (JE6, pp. 17-18)

On March 10, 2014, Ms. Lovan returned to see Dr. Yanish. She continued to exhibit symptoms of numbness and tingling in both hands. She reported that her symptoms were aggravated by working, driving the car, talking on the phone, and while sleeping at night. Dr. Yanish stated, "[t]he patient has a history of having surgical release of bilateral carpal tunnel with recurrence of her symptoms secondary to scar tissue buildup in the carpal tunnel canal." (JE6, p. 19) Ms. Lovan opted to undergo the open carpal tunnel release with hypothenar fat pad transposition. The doctor noted that the surgery would be performed once approval through workers' compensation was approved. (JE6, pp. 19-20)

On July 23, 2014, Dr. Yanish opined that Ms. Lovan's condition was aggravated by her duties and was related to the original work comp injury. The doctor stated, "[t]his is an extremely unusual situation with recurrent carpal tunnel syndrome secondary to scar tissue, but the scar tissues stems from the original surgery, therefore, in my medical opinion the current condition is related to her work comp claim." (JE6, p. 22)

On September 9, 2014, Dr. Yanish performed left open carpal tunnel release with hypothenar fat pad flap. (JE10)

Ms. Lovan returned to Dr. Yanish's office on November 12, 2014 for impairment measurements. The measurements are set forth in the office note. (Defendants' Ex. A)

Dr. Yanish released Ms. Lovan to final restrictions of return to work full duty on November 12, 2014. (JE6, p. 23) On November 20, 2014, Dr. Yanish opined that Ms. Lovan had sustained two percent impairment for her left open carpal tunnel release. (JE6, p. 24)

The records demonstrate that on February 23, 2016, Todd J. Janus, M.D. conducted additional nerve studies. The impression from the studies was slightly abnormal EMG/nerve conduction study with loss of velocity in both the left and right median nerve. (JE11)

Ms. Lovan returned to see Dr. Yanish on March 23, 2016. She reported that the numbness and tingling had not resolved following the redo of her left carpal tunnel release. Her symptoms improved for a while but recently she had a recurrence of her discomfort. She reported subjective numbness and tingling in her left hand. Dr. Yanish explained to Ms. Lovan that he did not believe that her symptoms of continued numbness and tingling were related to carpal tunnel syndrome and did not feel she would benefit from any more surgical treatments. He was very confident that the left carpal tunnel was released. Dr. Yanish recommended that she seek a second opinion if she so desired. (JE6, pp. 25-26)

Ms. Lovan did not seek any medical treatment for her upper extremities from March 23, 2016 until she saw Eugene J. Cherny, M.D. on September 13, 2016. She testified that she did not seek out an opinion from a pain specialist or a rheumatologist. (Testimony)

At the request of her attorney, Ms. Lovan saw Dr. Cherny on September 13, 2016. Dr. Cherny reviewed Ms. Lovan's treatment records in addition to examining her. Ms. Lovan reported that she had been employed with Broadlawns for approximately 15 years. At the time of the exam, she was working as a correspondence clerk where she primarily performed clerical work including computer work and filing duties. Ms. Lovan reported to Dr. Cherny that her right upper extremity felt heavy and was often fatigued. Work above her shoulder level seemed to increase the symptoms. She also reported tingling in her fingers, primarily the right index, middle, and ring fingers. She also had an aching pain that limited her work and daily activities. Ms. Lovan reported that she has very similar symptoms in her left upper extremity; however, they were not as severe as in the right upper extremity. Dr. Cherny stated:

> She continues to have symptoms in both upper extremities as indicated above with the right worse than the left. I do feel that her ongoing

> symptoms can be casually related to her occupation at Broadlawns Medical Center and is a continuation of her prior claims to both upper extremities. Physical findings during today's exam suggest median neuropathy in the proximal forearm with the right greater than the left. I would recommend further exploration of the proximal forearm to rule out a pronator syndrome with a traditional longitudinal incision rather than the transverse incision type performed by Dr. Quenzer. It has been my experience that the pronator release surgical procedure has a suboptimal outcome when performing a transverse incision vs. a longitudinal incision. A longitudinal incision allows greater room for exploration to ensure a full release of the median nerve through this region.

(JE12, p. 10)

He recommended further exploration of the proximal forearm to rule out pronator syndrome with a traditional longitudinal incision rather than the transverse incision performed by Dr. Quenzer. Dr. Cherny noted that it had been "[his] experience that the pronator release surgical procedure has a suboptimal outcome when performing a transverse incision vs. a longitudinal incision. A longitudinal incision allows greater room for exploration to ensure a full release of the median nerve through this region." (Id.) If the procedure was successful, he would recommend similar treatment for the left upper extremity. Dr. Cherny noted that if she did not wish to proceed with surgery then he would agree that she is at maximum medical improvement (MMI). He set forth the basis for his impairment rating and ultimately assigned 39 percent impairment for the right upper extremity and 31 percent impairment to the left upper extremity. Dr. Cherny opined that Ms. Lovan's 15 years of work at Broadlawns including extensive keyboarding and filing activities were a contributing factor to her current conditions in her upper extremities. He recommended a re-exploration of the right forearm. He also recommended further exploration of the right proximal forearm and if she had a positive outcome he would recommend the same for the left upper extremity. He did not place any permanent restrictions on her activities. (JE12, pp. 1-13)

On January 29, 2018, additional nerve testing was performed on Ms. Lovan. This was performed by Irving Wolfe, D.O. at the request of claimant's attorney. The impression on the testing report indicated that findings supported dysfunction of the left ulnar nerve at the level of the elbow consistent with left-sided cubital tunnel syndrome and dysfunction of the left median nerve at the level of the wrist consistent with left-sided carpal tunnel syndrome. The study of the right upper extremity was normal. (JE13)

Ms. Lovan returned to Dr. Cherny on February 8, 2018. The doctor also reviewed updated nerve studies. He noted that the January 29, 2018 studies revealed objective findings to support ulnar neuropathy of the left elbow consistent with left cubital tunnel syndrome, as well as left median neuropathy at the level of the wrist consistent with left carpal tunnel syndrome. He felt that Ms. Lovan's range of motion in

both of her upper extremities was consistent with the range of motion he noted in September of 2016. Dr. Cherny felt that no change was necessary for the impairment rating based on range of motion. (JE12)

Dr. Cherny did note there was a progression of symptoms involving the median nerve distribution of both hands. He did not change the impairment rating to the right upper extremity; this remained 39 percent. However, he did adjust the impairment rating he assigned to the left upper extremity. He changed this from 31 percent of the left upper extremity to 40 percent of the left upper extremity. Dr. Cherny noted that Ms. Lovan continued to work as a clerk at Broadlawns. He also noted she had increased symptoms since he last saw her in September of 2016. He diagnosed her with possible right median neuropathy at the level of the wrist consistent with carpal tunnel syndrome; right median neuropathy in the proximal forearm consistent with pronator syndrome; left median neuropathy consistent with left carpal tunnel syndrome; and left ulnar neuropathy at the elbow consistent with left cubital tunnel syndrome. Dr. Cherny stated, "I do feel that the above diagnoses are directly related to her employment at Broadlawns medical center due to the repetitive standing and filing duties which she has performed over the last 15 years." (JE12, p. 19)

With regard to additional treatment, Dr. Cherny recommended injections into the carpal tunnels to see if she received any benefit. Depending on the outcome of the injections, she may or may not be a candidate for additional carpal tunnel release procedures. Dr. Cherny felt Ms. Lovan would benefit from a workstation evaluation and some physical therapy. (JE12)

At the request of the defendants, Ms. Lovan was evaluated by Benjamin S. Paulson, M.D. at Iowa Ortho for purposes of an independent medical evaluation (IME). Dr. Paulson reviewed the medical records provided to him and examined Ms. Lovan. Ms. Lovan reported bilateral hand numbness and tingling. She reported that she worked at Broadlawns for the past approximately 17 years. Her job duties included typing and talking on the phone most of her day. She reported to Dr. Paulson that the previous day her finger went numb and turned completely white. She experienced numbness with her fingertips and achiness and pain in her forearms. She also reported that her sleep was interrupted due to the numbness. (JE 14, pp. 5-10)

Dr. Paulson felt that clinically, Ms. Lovan did not have textbook carpal tunnel syndrome and did not seem to be symptomatic from her cubital tunnel syndrome. He felt her exam was more suggestive of either fibromyalgia or some other type of chronic pain syndrome. Due to her report of some whitening of a finger he also felt a possible diagnosis could be Raynaud's phenomenon. Dr. Paulson indicated that either possible Raynaud's or fibromyalgia would not be related to her work. He felt that even if she was not working at Broadlawns as a correspondence clerk, her upper extremities would have been just as symptomatic. However, he admitted he was not a pain expert and he does not consider himself to be an expert at diagnosing pain syndrome such as fibromyalgia. He would defer to a pain specialist or a rheumatologist.

Because Dr. Paulson felt that Ms. Lovan's current condition was not due to her work he did not recommend any additional work-related treatment. Dr. Paulson did not recommend any surgical intervention. Because Ms. Lovan had no significant improvement with her prior carpal tunnel releases he felt another release would not give her any significant improvement. Dr. Paulson acknowledged that Ms. Lovan seemed symptomatic, but he did not feel it was work related. He recommended a medical workup by a pain specialist or a rheumatologist.

Dr. Paulson felt that her diagnoses of carpal tunnel syndrome and pronator syndrome were not work related. Additionally, he disagreed with Dr. Cherny's impairment rating. He felt it was artificially inflated because it was based on a significant loss of range of motion that was not consistent with the findings in her treatment records and with his own exam of Ms. Lovan. Additionally, he felt the rating was too high because she had a large impairment rating due to peripheral nerve compression on the right even though her nerve conduction study was normal. Based on Dr. Paulson's exam, he would assign four percent of the right upper extremity due to loss of range of motion, combined with two percent for peripheral neuropathy, for a total of six percent of the right upper extremity. For the left upper extremity, he assigned six percent for loss of range of motion and three percent for peripheral nerve compression, for a total of nine percent of the left upper extremity. He did not feel there was any need for any permanent restrictions. (JE14, pp. 5-10)

Ms. Lovan testified that when she left Dr. Paulson's office she was under the impression that he was going to request authorization from workers' compensation to provide her treatment. She was willing to receive treatment from him at that time. However, since that appointment she has had the opportunity to read his report. In light of his opinion regarding causation, she no longer wants to treat with Dr. Paulson. Rather, she wants to treat with Dr. Cherny. (Testimony)

Ms. Lovan testified that she believes her current symptoms are related to her work at Broadlawns. These include numbness, tingling, and shooting pain in her upper extremities. She testified that her symptoms are constant. Both hands feel numb when she sleeps. Her primary care physician, Dr. Maher prescribes medication that she takes to help her sleep at night. Ms. Lovan feels that her symptoms now are the same as they were around the time of the date of injury. She feels her symptoms have not changed, if anything they have gotten worse. Any relief she received from the various treatments was temporary. She experiences pain while driving or talking on the phone. She has a headset when she talks on the phone at work. (Testimony)

Ms. Lovan has returned to her job as a correspondence clerk working regular duties, full-time. She is earning more now than she was at the time of the injury. She does not have any restrictions placed on her activities. She performs a lot of computer and typewriter work. She also helps patients complete handwritten forms. Her hand goes numb when she writes. She no longer needs to lift heavy files or push carts of files because the records are now electronic. She has not had to pull charts since

before the 2014 surgery. In other words, she no longer has to perform the physical chart work that she had to perform in 2008. She loves her job and wants to continue working there. (Testimony)

Jeffrey Johannes, claimant's significant other, also testified at the hearing. He attended most of the medical appointments with Ms. Lovan. He testified about his observations of the examinations that Dr. Paulson and Dr. Cherny performed. He was not certain why treatment with Dr. Cherny had been put on hold. (Testimony)

The first issue to be determined is whether claimant's ongoing symptoms are related to the work injury. Defendants argue that claimant's ongoing symptoms are not work related. In doing so, defendants rely on the opinions of Dr. Paulson and the March 23, 2016 opinion of Dr. Yanish. However, I do not find these opinions to be persuasive. Dr. Paulson's report lacks convincing rationale to support his opinion that her current condition, which he does not have a definitive diagnosis for, is not work related. Dr. Paulson simply suggested other potential diagnoses and then stated he would defer to a pain specialist or rheumatologist regarding those diagnoses. (JE14) I find that Dr. Paulson's opinion regarding causation does not carry great weight.

Dr. Yanish treated Ms. Lovan for several years and performed two of her four surgeries. Throughout his treatment of Ms. Lovan, he causally connected her conditions to her work and obtained authorization from the workers' compensation carrier for the surgeries he performed. Dr. Yanish provided convincing rationale for why he felt her symptoms were related to her work. He stated, "[t]he patient has a history of having surgical release of bilateral carpal tunnel with recurrance [*sic*] of her symptoms secondary to scar tissue buildup in the carpal tunnel canal." (JE6, p. 19) At another point during his treatment he further explained, "[t]his is an extremely unusual situation with recurrent carpal tunnel syndrome secondary to scar tissue, but the scar tissues stems from the original surgery, therefore, in my medical opinion the current condition is related to her work comp claim." (JE6, p. 22) However, the last time Dr. Yanish saw Ms. Lovan, he stated that he did not believe her symptoms of continued numbness and tingling were related to carpal tunnel syndrome. The only explanation he provided was that he was very confident that the left carpal tunnel was released. He provides no explanation of how he can be so confident that the left carpal tunnel was released in light of the patient's previous recurrent carpal tunnel secondary to scar tissue. The undersigned finds that the rationale provided by Dr. Yanish in his March of 2016 note is not persuasive. Thus, I find Dr. Yanish's prior opinions regarding causation to be more persuasive.

Dr. Cherny has also provided his opinion on causation. Dr. Cherny has not provided any treatment to Ms. Lovan, but he has examined her on two separate occasions. Dr. Cherny first saw Ms. Lovan in September of 2016. At that time, he opined that her 15 years of work at Broadlawns, which included extensive keyboarding and filing activities were a contributing factor to her upper extremity conditions. (JE12, p. 12) In his report, Dr. Cherny set forth his rationale for why he felt she had obtained

suboptimal results from the surgical treatment and made recommendations for additional treatment. He saw Ms. Lovan again in February of 2018. He still causally connected her condition to her employment. (JE12, pp. 19-20)

For the above-stated reasons, I find that the greater weight of the persuasive expert opinions demonstrates that claimant's ongoing upper extremity complaints are related to the work injury. I find that Ms. Lovan has carried her burden of proof to show by a preponderance of the evidence that her ongoing upper extremity complaints are related to the stipulated injury.

Claimant is seeking alternate medical care for her upper extremities. Defendants have denied liability for Ms. Lovan's ongoing complaints. However, the undersigned has herein determined that her ongoing complaints are related to the work injury. As such, I find that defendants are responsible for the reasonable and necessary medical treatment related to the injury.

We now turn to the issue of permanency. The parties have stipulated that any permanency benefits shall commence on November 12, 2014. As set forth above, there are several experts who have offered their opinions regarding the amount of permanent functional impairment sustained by Ms. Lovan. Of those experts, I find that the permanency opinion set forth by Dr. Bahls carries the greatest weight. Dr. Bahls assigned five percent upper extremity impairment for both arms due to residual carpal tunnel syndromes. Dr. Bahls noted that because the symptoms affected Ms. Lovan's sleep and function at work and at home she assigned another three percent whole person impairment for pain. The total impairment assigned by Dr. Bahls equated to a total of nine percent whole person impairment. (JE6, p. 16) Dr. Bahls set forth the basis and rationale for her opinions. Dr. Bahls also demonstrated an understanding of Ms. Lovan's symptoms and need for medications. I find Dr. Bahls' opinion with regard to impairment to be consistent with Ms. Lovan's testimony regarding her ongoing symptoms and therefore find it to be persuasive. (JE6, p. 16) With regard to the issue of permanent functional impairment, I find the opinions of Dr. Bahls to carry the greatest weight and adopt her functional impairment rating. Thus, I conclude that Ms. Lovan has sustained nine percent whole person impairment.

Having considered that claimant has returned to work for the employer, and considering claimant's testimony about her ongoing symptoms and abilities, I find that the 45 percent permanent impairment rating is consistent and is an appropriate estimate of claimant's permanent functional disability as a result of the injury to her bilateral upper extremities.

Defendants have asked for an assessment of costs in this matter. I find that defendants were generally not successful in this case. As such, I exercise my discretion and find that an assessment of costs against the claimant is not appropriate. Each party shall bear their own costs.

CONCLUSIONS OF LAW

The party who would suffer loss if an issue were not established ordinarily has the burden of proving that issue by a preponderance of the evidence. Iowa Rule of Appellate Procedure 6.14(6)(e).

The claimant has the burden of proving by a preponderance of the evidence that the injury is a proximate cause of the disability on which the claim is based. A cause is proximate if it is a substantial factor in bringing about the result; it need not be the only cause. A preponderance of the evidence exists when the causal connection is probable rather than merely possible. George A. Hormel & Co. v. Jordan, 569 N.W.2d 148 (Iowa 1997); Frye v. Smith-Doyle Contractors, 569 N.W.2d 154 (Iowa App. 1997); Sanchez v. Blue Bird Midwest, 554 N.W.2d 283 (Iowa App. 1996).

The question of causal connection is essentially within the domain of expert testimony. The expert medical evidence must be considered with all other evidence introduced bearing on the causal connection between the injury and the disability. Supportive lay testimony may be used to buttress the expert testimony and, therefore, is also relevant and material to the causation question. The weight to be given to an expert opinion is determined by the finder of fact and may be affected by the accuracy of the facts the expert relied upon as well as other surrounding circumstances. The expert opinion may be accepted or rejected, in whole or in part. St. Luke's Hosp. v. Gray, 604 N.W.2d 646 (Iowa 2000); IBP, Inc. v. Harpole, 621 N.W.2d 410 (Iowa 2001); Dunlavey v. Economy Fire and Cas. Co., 526 N.W.2d 845 (Iowa 1995). Miller v. Lauridsen Foods, Inc., 525 N.W.2d 417 (Iowa 1994). Unrebutted expert medical testimony cannot be summarily rejected. Poula v. Siouxland Wall & Ceiling, Inc., 516 N.W.2d 910 (Iowa App. 1994).

Based on the above findings of fact, I concluded that claimant's ongoing upper extremity complaints are the result of the stipulated May 1, 2008 work injury.

Ms. Lovan is seeking additional permanent disability benefits for the stipulated bilateral upper extremity injury. Benefits for permanent partial disability of two members caused by a single accident is a scheduled benefit under section 85.34(2)(s); the degree of disability must be computed on a functional basis with a maximum benefit entitlement of 500 weeks. Simbro v. DeLong's Sportswear, 332 N.W.2d 886 (Iowa 1983).

Under the Iowa Workers' Compensation Act, permanent partial disability is compensated either for a loss or loss of use of a scheduled member under Iowa Code section 85.34(2)(a)-(t) or for loss of earning capacity under section 85.34(2)(u). The extent of scheduled member disability benefits to which an injured worker is entitled is determined by using the functional method. Functional disability is "limited to the loss of the physiological capacity of the body or body part." Mortimer v. Fruehauf Corp., 502 N.W.2d 12, 15 (Iowa 1993); Sherman v. Pella Corp., 576 N.W.2d 312 (Iowa 1998). The

fact finder must consider both medical and lay evidence relating to the extent of the functional loss in determining permanent disability resulting from an injury to a scheduled member. Terwilliger v. Snap-On Tools Corp., 529 N.W.2d 267, 272-273 (Iowa 1995); Miller v. Lauridsen Foods, Inc., 525 N.W.2d 417, 420 (Iowa 1994).

Benefits for permanent partial disability of two members caused by a single accident is a scheduled benefit under section 85.34(2)(s); the degree of disability must be computed on a functional basis with a maximum benefit entitlement of 500 weeks. Simbro v. DeLong's Sportswear, 332 N.W.2d 886 (Iowa 1983).

Having accepted the impairment rating of Dr. Bahls, I found that claimant proved a 9 percent permanent impairment of the whole person. Similarly, I found that the impairment rating offered by the Guides was a reasonable estimate of the functional disability sustained by claimant when considering her own testimony about her residual symptoms and abilities. Thus, I conclude that claimant is entitled to a permanent partial disability award equivalent to 9 percent of the body as a whole. Therefore, I conclude that claimant is entitled to an award of 45 weeks of permanent partial disability benefits. Iowa Code section 85.34(2)(s). These benefits shall commence on the stipulated date of November 12, 2014.

The employer shall furnish reasonable surgical, medical, dental, osteopathic, chiropractic, podiatric, physical rehabilitation, nursing, ambulance, and hospital services and supplies for all conditions compensable under the workers' compensation law. The employer shall also allow reasonable and necessary transportation expenses incurred for those services. The employer has the right to choose the provider of care, except where the employer has denied liability for the injury. Section 85.27. Holbert v. Townsend Engineering Co., Thirty-second Biennial Report of the Industrial Commissioner 78 (Review-Reopening October 1975).

Based on the above findings of fact, I concluded that Ms. Lovan's ongoing upper extremity complaints are related to the stipulated work injury. As such, defendants are responsible for providing reasonable and necessary medical treatment. Defendants shall authorize reasonable and necessary treatment causally related to the work injury.

For the reasons set forth above, I conclude each party shall bear their own costs. 876 IAC 4.33.

ORDER

THEREFORE, IT IS ORDERED:

All weekly benefits shall be paid at the stipulated rate of two hundred ninety-five and 73/100 dollars ($295.73).

Defendants shall pay forty-five (45) weeks of permanent partial disability benefits commencing on November 12, 2014. Defendants shall be entitled to credit for all weekly benefits paid to date.

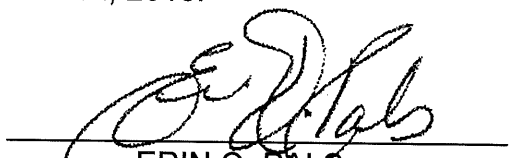
All past due weekly benefits shall be paid in lump sum with applicable interest pursuant to Iowa Code section 85.30.

Defendants shall provide reasonable and necessary medical treatment causally connected to the work injury.

Each party shall bear their own costs.

Defendants shall file subsequent reports of injury (SROI) as required by this agency pursuant to rules 876 IAC 3.1(2) and 876 IAC 11.7.

Signed and filed this 30th day of March, 2018.



ERIN Q. PALS
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Right to Appeal: This decision shall become final unless you or another interested party appeals within 20 days from the date above, pursuant to rule 876 4.27 (17A, 86) of the Iowa Administrative Code. The notice of appeal must be in writing and received by the commissioner's office within 20 days from the date of the decision. The appeal period will be extended to the next business day if the last day to appeal falls on a weekend or a legal holiday. The notice of appeal must be filed at the following address: Workers' Compensation Commissioner, Iowa Division of Workers' Compensation, 1000 E. Grand Avenue, Des Moines, Iowa 50319-0209.